

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

02474

## CERTIFICATE OF DEATH

Reg. Diat. No. 66

### 1. PLACE OF DEATH:

County

City or town

Ridgeley

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3.5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Alice Laird Bennington

4. Sex

F

5. Color or race

6. (c) Single, married, widowed, or divorced

W. widow

6. (b) Name of husband or wife

H. E. Bennington

7. Birth date of deceased (mo., day, yr.)

June 3 my 1864

8. (c) If alive, give age years

8. AGE:

Years  
81

Months  
8

Days  
6

If less than one day  
hrs. min.

9. Birthplace

Pawtucket, Maryland

(Town, county, and state)

10. Usual occupation

Telephone Operator

11. Industry or business

Flight to Laurel

12. Name

Mary Boyd

13. Birthplace

Maryland

14. Maiden name

Mary Boyd

15. Birthplace

Maryland

16. Informant

Walter Bennington

Address

Ridgeley, W. Va.

11. Buried

(Burial, cremation, or removal. Which?)

Date thereof 3/10/46

(month) (day) (year)

Cemetery or crematory

Ridgeley Cemetery

Location

Ridgeley, W. Va.

18. Funeral director

J. Virgil Evans & Son

Address

Denton, W. Va.

19. Date rec'd by registrar

March 9, 1946

(Date rec'd by registrar)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Caroline

City or town Ridgeley

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

2D. DATE OF DEATH

March 7, 1946 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 20, 1946 to March 7, 1946

and that I last saw her alive on March 6, 1946

Immediate cause of death

Central Hemorrhage

DURATION

15 days

Due to arteriosclerosis and hypertension

4 yrs +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul M. Thomas

M. D. or other

Address Denton, W. Va. Date signed 3/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-12

03108

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County.....

City or town.....

Caroline

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

26 years

Hospital, Institution, or street address where death occurred:.....

R.I.D.

How long in hospital or institution?.....

no

## 3. (a) FULL NAME

G. G. Brittain Sr.

4. Sex

M.

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

Lucy G. Brittain

## 7. Birth date of deceased (mo., day, yr.)

December 6, 1872

6(c) If alive, give age 70 years

## 8. AGE:

73

2

29

Days If less than one day

hrs.

min.

## 9. Birthplace.....

See County of a.

(Town, county, and state)

## 10. Usual occupation.....

retired farmer

## 11. Industry or business

" "

M

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FATHER

Chadwell Brittain

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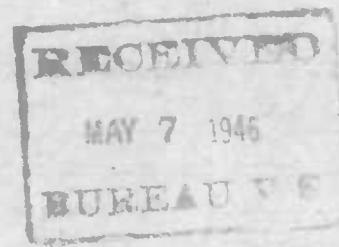
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Evidence for addition of age  
& birth date of deceased is  
shown on

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 13

02475

FILM NO. 101 MAR 19 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

Cal

married

8. (b) Name of husband or wife

9. Birthdate of deceased (mo., day, yr.)

Aug. 18, 1895

8. AGE:

Years

Months

Days

if less than one day

50

6

13

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Day Labor on farm.

11. Industry or business

Kearcellis Brown

12. Name

Mother Father

13. Birthplace

Hillsboro

14. Maiden name

Annie

15. Birthplace

Hillsboro Ind.

16. Informant

T. D. Brown

Address

Hillsboro Ind.

17. Buried

(Burial, cremation, or removal. Which?)

Date thereof 3-5-46

(month) (day) (year)

Cemetery or crematory Sand Lound Cemetery

Location

Near Hillsboro

18. Funeral director

J. Virgil Brown &amp; Son

Address

Denton Ind.

19. Mar 5

(Date rec'd by registrar) 19-6

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1946 at .....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 1946, to March 1 1946

and that I last saw him alive on March 1 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

B. H. &amp; W. S. Davis M. D. Steeple Greenbriar Ind. Date Signed 1946

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02476

932

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County CarolineCity or town Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yearsHospital, institution, or street address where death occurred: Greenvale Road

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret W. Cade4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 12, 1861 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 84 Months 11 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Sussex County, Delaware  
(Town, county, and state)10. Usual occupation Housework11. Industry or business HomeMOTHER FATHER 12. Name John Cade  
13. Birthplace Sussex County, Delaware14. Maiden name Elizabeth Barwick  
15. Birthplace Sussex County, Delaware16. Informant Mrs. Frank L. WilliamsAddress Federalsburg, Maryland17. Burial Burial Date thereof March 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Denton CemeteryLocation Denton, Maryland18. Funeral director J. S. Frampton and SonAddress Federalsburg, Maryland19. March 16 1946 J. S. Frampton  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Greenvale Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946 at 1 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 12 1946 to Mar 15 1946 and that I last saw her alive on Mar 15 1946.

Immediate cause of death

Congestive Heart Failure

Due to

Hypertension & Myocarditis

Due to

Myocarditis

DURATION

2 weeks10 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

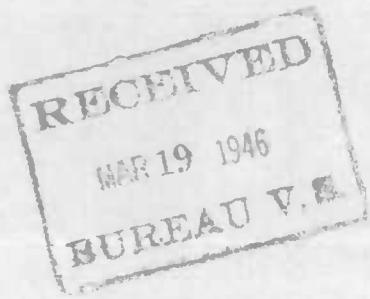
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank M. Anderson M.D. M. D. or otherAddress Federalsburg, Maryland Date signed 3/16/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

02477  
60

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

Caroline  
Goldsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)  
85 yrs.

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Rebecca Catherine

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

White

Widowed

6. (b) Name of husband or wife.....

William

7. Birth date of

deceased (mo., day, yr.)

Oct. 17, 1861

6. (c) If alive, give age..... years

8. AGE:

Years      Months      Days      If less than one day

84

4

30

....hrs. ....min.

9. Birthplace.....

Goldsboro Caroline Md.

(Town, county, and state)

10. Usual occupation.....

House wife

11. Industry or business

Joseph Huston

12. Name.....

Maryland

13. Birthplace.....

Mary E. Stubbs

14. Maiden name.....

Maryland

15. Birthplace.....

Bertie Stubbs

16. Informant.....

Goldsboro Md.

Address.....

Burial

(Burial, cremation, or removal? Which?)

Date thereof..... 3/20/46  
(month) (day) (year)

Cemetery or crematory.....

Greensboro

Location.....

Greensboro, Md.

18. Funeral director.....

Raymond B. Rawlings

Address.....

Greensboro Maryland

19. Date rec'd by registrar.....

3/18 1946 J.C. Smith

Registrar.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County.....

Goldsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 16 1946, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1944 to Mar. 15 1946 and that I last saw her alive on March 15 1946

immediate cause of death.....

Stroke / Hypocarditis

Due to.....

Arteriosclerosis  
Cardiac muscular Disease

Due to.....

Pneumonia

Other condition.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

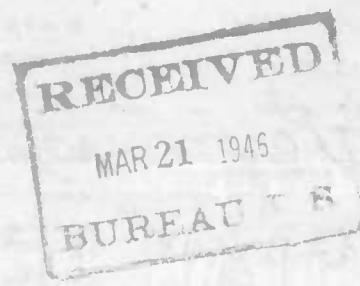
Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

Signature..... M. D. or C. E. or R. S. or other initials

Address..... Date signed.....

Greensboro, Md. 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

02478

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....

City or town.....

Caroline  
Pearl

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

20 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mrs. Bertrude Foos

4. Sex

Fr

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widow.

6. (b) Name of husband or wife.....

John Foos

7. Birth date of deceased (mo., day, yr.)

Sept 20<sup>th</sup> 1865

B. (c) If alive, give age.....

years

8. AGE:

Years

Months

Days

If less than one day  
hrs. min.

9. Birthplace.....

Germany

(Town, county, and state)

10. Usual occupation.....

at home

11. Industry or business

MOTHER FATHER

12. Name.....

John Porter

13. Birthplace

England

14. Maiden name.....

Daisy Ward

15. Birthplace

Germany

16. Informant.....

Mrs Anna Stupford

Address

Seaford Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Tully George Cemetery

Location.....

Md. &amp; Del.

18. Funeral director.....

J. Virgil Almon &amp; Son

Address

Delmar Md

19. (Date rec'd by registrar)

3/5

1946

Mo

10

Year

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 3

1946 at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 26 1946 to March 3 1946

and that I last saw her alive on March 2 1946

Immediate cause of death.....

arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

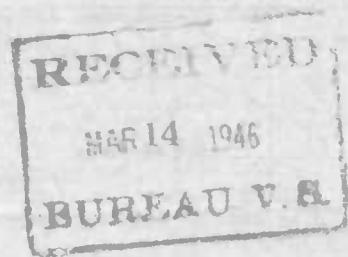
Paul Throth MD

M. D. or other

Address.....

Delmar Md

Date signed 3/4/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

952

## CERTIFICATE OF DEATH

02479 62

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

Caroline Hillsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)  
9 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Herman F. Hill  
Male White Married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years Months Days If less than one day  
70 18 16 hrs. min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial (Burial, cremation, or removal? Which?).....

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

1946 M.A.O. George

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 1942 to March 29 1946, and that I last saw him alive on March 16 1946.

Immediate cause of death.....

Coronary thrombosis

Due to.....

Generalized arterio-sclerosis

Due to.....

Other conditions.....

Emphysema of the lungs, degenerative changes, several years

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

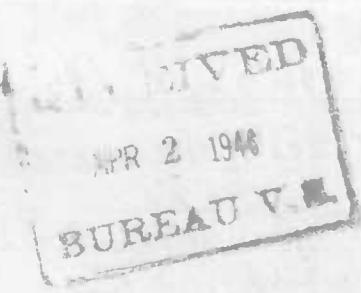
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information given is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B2)*

02480

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

*35 yrs.*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

18. Informant

Address

17. Burial

(Burial, cremation, or removal? Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

19. Date signed

20. Date of op.

21. Date of death

22. Violence

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Address

23. Signature

M. D. or C. M. E.

Date signed

24. Address

25. Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*March 27, 1946, at 11:45 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*March 22, 1946, to March 27, 1946,*and that I last saw her alive on *March 27, 1946.*

Immediate cause of death

*Bronchitis, Pneumonia*

DURATION

*2 day.*

Due to

Due to

Other conditions

*Chronic Myocarditis  
+ Hypertension*

(Indicate pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature

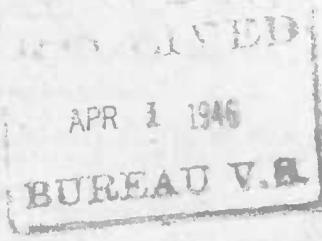
M. D. or C. M. E.

Date signed

Date signed

Address

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

02481

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

full life

Hospital, Institution, or street address where death occurred:.....

2 S. St. — Concord —

How long in hospital or institution?.....

no

## 3. (a) FULL NAME

Alva Hubbard

4. Sex

m.

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife.....

Hattie Hubbard

7. Birth date of deceased (mo., day, yr.)

February 16, 1870

6.(c) If alive, give age..... years

54

8. AGE: Years

75

Months

—

Days

21

If less than one day

hrs.

min.

9. Birthplace.....

Federalsburg, Md.

(Town, county, and state)

10. Usual occupation.....

farmer

11. Industry or business.....

"

MOTHER

FATHER

12. Name.....

Wm. J. Hubbard

13. Birthplace.....

Md.

14. Maiden name.....

Sarah A. Wright

15. Birthplace.....

Md.

16. Informant.....

Mrs. Alva Hubbard

Address

Burlin

17. (Burial, cremation, or removal, which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19. Date rec'd by registrar.....

Date signed.....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

no

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3 - 7 - 1946 19..... at 3 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1, 1942 to Mar. 7, 1946, 19. 46

and that I last saw h. m. alive on Mar. 6, 1946, 19. 46

Immediate cause of death.....

Cardio Vasculon Renal  
diseases

DURATION

493

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

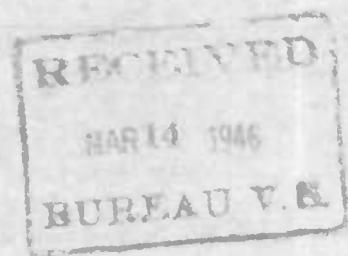
Means of injury.....

Injured at work?

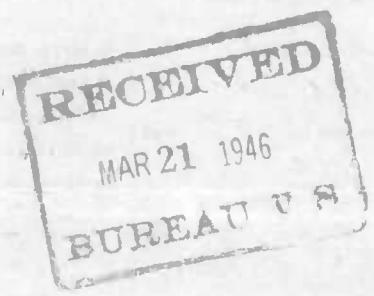
23. SIGNATURE.....

M. D. or other

Address..... Date signed.....







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02483

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH: Caroline  
County: Greensboro

City or town: Greensboro (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma Kilson

4. Sex

F. Color or race B. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 10 (c) If alive, give age years 1885

8. AGE: Years 61 Months 2 Days 11 It less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Nursing work

11. Industry or business

MOTHER FATHER Nathan Benson

MOTHER FATHER Maryland

14. Maiden name Unknown

15. Birthplace Unknown

18. Informant Jack Byssone

Address Greensboro, Md.

17. Burial Date thereof 3/27/46 (Burial, cremation, or removal - When) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Near Maryland, Md.

18. Funeral director Raymond H. Sawtngs

Address Greensboro, Md.

19. Date rec'd by registrar Mar. 23 1946 of Mon Pegein Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Marydel

City or town Marydel (If outside city or town limits, write RURAL and give nearest town) Rural

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 16 1946, to March 21 1946,

and that I last saw her alive on March 21 1946.

Immediate cause of death

Tuberculosis

DURATION

1 yr

Due to Cards Pneumonia

Diseases of the future

Q1

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

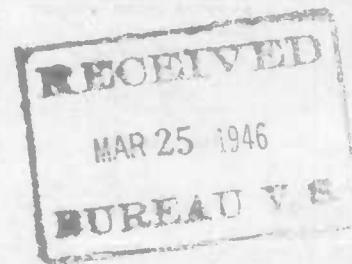
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Caroline S. Saenger M.D. Greensboro, Md. Date signed Mar. 22 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

02484

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

## 1. PLACE OF DEATH:

County.....

Caroline Henderson Rural

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

44 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Christian Kusmaul

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 23, 1897

8. AGE: Years

Months

Days

If less than one day

48

7

18

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Russia

10. Usual occupation.....

Farmer

11. Industry or business

12. Name.....

John Kusmaul

13. Birthplace

Russia

14. Maiden name.....

Christina Milka

15. Birthplace

Russia

16. Informant.....

Mrs. Kusmaul

Address

Henderson Rural

17. Burial

Greensboro

(Burial, cremation, or removal Whiche?)

Date thereof..... (month) (day) (year)

Cemetery or cemetery

Greensboro

Location

Md.

18. Funeral director.....

Raymond B. Rawlings

Address

Greensboro, Md.

19. Date rec'd by registrar

3/13/46

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County..... Caroline

City or town.....

Henderson Rural

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

World war #1

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 10 1946 at 315A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Dec 14 to March 1946

and that I last saw him alive on Mar 2 1946

Immediate cause of death.....

Exhaustion

Due to.....

Pulmonary Tuberculosis 6 mo.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

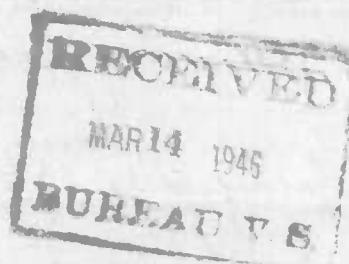
Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE.....

J. G. Silver Goldsboro M.D.

Date signed 3/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bi-a*

02485

Reg. Dist. No. 61

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

City or town..... *Near Deleto*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Lettie Mitchell*

4. Sex

*F*

5. Color or race

*Wh.*

6. (a) Single, married, widowed, or divorced

*Single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Jan. 17 1907

6. (c) If alive, give age..... years

8. AGE:

Years  
*39*Months  
*6*Days  
*1*If less than one day  
hrs. .... min.

9. Birthplace.....

*Near Deleto*

(Town, county, and state)

10. Usual occupation.....

*at home*

11. Industry or business

*Frank Mitchell*

12. Name.....

*Frank Mitchell*

13. Birthplace

*Deleto*

14. Maiden name.....

*Martha Layton*

15. Birthplace

*Maryland*

16. Informant.....

*Mr. Frank Mitchell (Father)*

Address

*81. Deleto*

17. Burial

*Burial*

Date thereof.....

(month) (day) (year)

Cemetery or crematory

*Greensboro*

Location

*Greensboro, Md.*

18. Funeral director.....

*J. T. Moore*

Address

*Deleto, Md.*

19. Date rec'd by registrar

*March 30, 1949*

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Caroline

City or town.....

Near Goldsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Rural

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 28

1946 at 4:26 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1946, March 28 1946, and that I last saw her alive on March 28 1946.

Immediate cause of death.....

*Cerebral Hemorrhage**or hemiplegia*

Due to.....

*Claude Reva Disease*

Due to.....

*Effort*

DURATION

*4 da*

(Include pregnancy within 3 months of death)

Major findings or operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

*Frank X. Stonerfield*

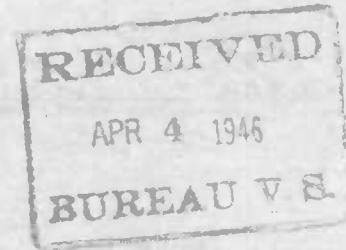
M. D. Reg. No. 44

Address.....

*Gainesboro, Md.*

Date signed.....

*29*



PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02486

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County.....

Caroline  
Near Deuelin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Richard Thomas Porter

4. Sex: M. 5. Color or race: S. 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Mrs Margaret Porter

7. Birth date of deceased (mo., day, yr.) Aug. 17<sup>th</sup> 1870 6.(c) If alive, give age: 60 years

8. AGE: Years: 75 Months: 7 Days: 20 If less than one day: hrs. min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: leather

FATHER: 12. Name: Porter

13. Birthplace: Maryland

MOTHER: 14. Maiden name: Margaret Garrett

15. Birthplace: Maryland

16. Informant: Mrs Margaret Porter (wife)

Address: Pg. 1 Deuelin. Md.

17. Burial: Cemetery Date thereof: 3-29-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Deuelin Cemetery

Location: Deuelin Md

18. Funeral director: G. Virgil Moore &amp; Son

Address: Deuelin Md.

19. Date rec'd by registrar: 3/29/46 1946 Date of death: 3-26-46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md

County: Caroline

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1946 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 24 1946 to Mar. 26 1946

and that I last saw h. com. alive on Mar. 26 1946

Immediate cause of death:

Coronary Thrombosis 2 da

Due to:

Arteriosclerosis

Due to: Cerebral vascular Disease 01

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of:

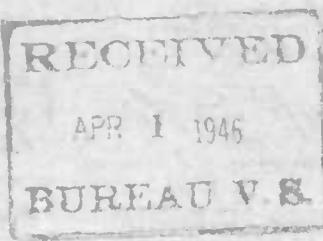
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE:

Clark & Horwitz, MD M.D. or other  
Greensboro, Md. Date signed 3/27/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *R.D.*

02487

## CERTIFICATE OF DEATH

Reg. Dist. No. *63*

## 1. PLACE OF DEATH:

County..... Caroline

City or town..... Bethlehem

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 36 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

W. Wesley Prettyman, Sr.

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Male

White

Widower

## B.(b) Name of husband or wife.....

Emma A. Prettyman

## 6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

Jan 19, 1866

## 8. AGE:

Years

Months

Days

If less than one day

80

1

12

hrs.

min.

## 9. Birthplace.....

Laurel, Del.

(Town, county, and state)

## 10. Usual occupation.....

Farmer

## 11. Industry or business

MOTHER FATHER

John Wesley Prettyman

## 13. Birthplace

Delaware

## 14. Maiden name.....

Hannah Truitt

## 15. Birthplace

Delaware

## 16. Informant.....

Bernice P. Higgins

## Address

Preston, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Mar 4, 1946

(month) (day) (year)

## Cemetery or crematory

Spring Hill

## Location

Easton, Md.

## 18. Funeral director.....

H. M. Hollis

## Address

Preston, Md.

3/4

19. 46

C. D. Plummer

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County.....

Caroline

City or town..... Bethlehem

(If outside city or town limits, write RURAL and give nearest town)

Street No..... RFD

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

March 20<sup>th</sup> 1946 at 3A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb.

1933 to March

1946

end that I last saw him alive on Feb. 28<sup>th</sup>

1946

Immediate cause of death.....

Valvular heart disease 12 yrs.

Due to.....

Arterio sclerosis

DURATION

15 yrs.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

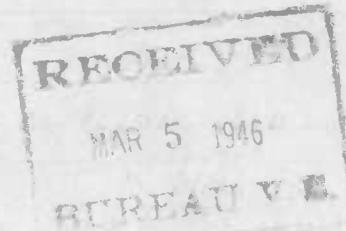
Injured at work?

## 23. SIGNATURE

William S. Reynolds

M. D. or other

Address..... Easter, Md. Date signed..... 3/4/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03109

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County CarolineCity or town Federalburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LifeHospital, Institution, or street address where death occurred: Academy Avenue

How long in hospital or institution?

## 3. (a) FULL NAME

Lettie F. Stevens

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed

## 6.(b) Name of husband or wife

Edward Stevens

## 6.(c) If alive, give age

years

## 7. Birth date of deceased (mo., day, yr.)

March 22, 1868

## 8. AGE:

Years

Months

Days

If less than one day

77

11

21

hrs.

min.

## 9. Birthplace

Federalburg, Maryland

(Town, county, and state)

## 10. Usual occupation

Housework

## 11. Industry or business

Home

MOTHER FATHER

## 12. Name

Joseph T. Frampton

## 13. Birthplace

Talbot County, Maryland

## 14. Maiden name

Caroline Dilahay

## 15. Birthplace

Dorchester County, Maryland

## 16. Informant

Mrs. Francis Neal

## Address

Federalburg, Maryland

## 17. Burial

Date thereof March 15 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Hill Crest Cemetery

## Location

Federalburg, Maryland

## 18. Funeral director

J. J. Frampton and Son

## Address

Federalburg, Maryland

## 19. Date rec'd by registrar

March 15 1946

(Date rec'd by registrar)

S. S. Frampton

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarolineCity or town Federalburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Academy Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 13 1946, a.m. 1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 11946, to Mar. 13 1946

and that I last saw h.e.f.a. alive on

Mar. 13, 1946

## Immediate cause of death

Chronic Myocarditis

DURATION

3 yrs.

## Due to

Arteriosclerosis & Hypertension

5 yrs.

## Due to

Malaria

(Include pregnancy within 8 months of death)

Accidental fall, formerly 34th, 1945, circ. 60.

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

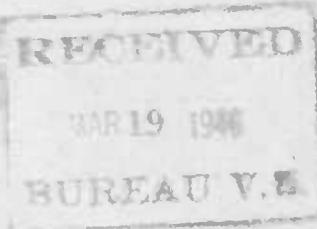
Injured at work?

## 23. SIGNATURE

Frank M. Jefferson

M. D. or other

Address Federalburg MdDate signed 3/16/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1402

02488

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County CarolineCity or town Denton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LifeHospital, Institution, or street address where death occurred: Lincoln Street

How long in hospital or institution?

## 3. (a) FULL NAME

Lillie A. Tucker

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Samuel L. Tucker

7. Birth date of deceased (mo., day, yr.)

September 28, 1880

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years  
65Months  
5Days  
14

If less than one day

hrs.

min.

9. Birthplace

Denton, Caroline County, Maryland

(Town, county, and state)

10. Usual occupation

Midwife

11. Industry or business

FATHER

12. Name John J. Barnes

MOTHER

13. Birthplace Norfolk, Virginia

MOTHER

14. Maiden name Sarah G. Pennington

15. Birthplace

Talbot County, Maryland

16. Informant

Mrs. Dolly L. Tribble

Address

Denton, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 17, 1946

(month) (day) (year)

Cemetery or crematory

Denton Colored Cemetery

Location

Denton, Maryland

18. Funeral director

J. J. Trampeton and Son

Address

Frederick, Maryland

19. Date rec'd by registrar

3/14/461946Marie O'GeorgeRegistrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Caroline

City or town

Denton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Lincoln Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 12, 1946 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw h..... alive on

Immediate cause of death

Due to Cardiac Accidents Sudden DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hudson George Carr

M. D. or other

Address

Denton

Date signed

3/14/46

RECEIVED  
MAR 18 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

## CERTIFICATE OF DEATH

0248966  
Reg. Dist. No.

## 1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
2 days.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Agnes Regina Wheeler.

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Jan 12, 1946

6.(c) If alive, give age..... years

8. AGE:

Years

Months

2

Days

5

If less than one day

hrs. .... min.

9. Birthplace

Laredo, Texas, California, 2nd

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

Clarence Wheeler

12. Name

Clydeville Avenue, Md.

13. Birthplace

Clydeville Avenue, Md.

14. Maiden name

Virginia Carter

15. Birthplace

Huntington, West Virginia

16. Informant

Virginia Wheeler

Address

Avenue, Md.

17. Burial

Burial

(Burial, cremation, or removal Which?)

Date thereof 3/19/46

(month) (day) (year)

Cemetery or crematory

Thomas Lown

Location

Near Ridgely, Md.

18. Funeral director

Raymond B. Rawlings

Address

Greensboro, Md.

19. Date rec'd by registrar

March 18, 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Anne Arundel

City or town.....

Queen Anne

County.....

Rural

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 17, 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13, 1946, to March 17, 1946,

and that I last saw her alive on March 16, 1946.

Immediate cause of death

Pneumonia

DURATION

3 day

Due to

Due to

Other conditions

Under nutrition

Since birth

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of.....

Where did injury occur? (City or town) (County) (State)

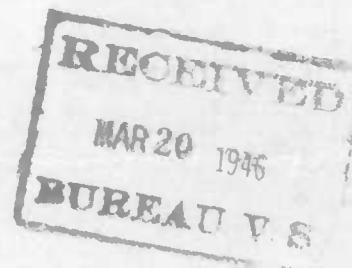
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Death &amp; Hospitalized M. D. Physician

Decedent died Date signed

Greene Ave, Md. 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83D

## CERTIFICATE OF DEATH

Reg. Dist. No. 02490

1. PLACE OF DEATH:  
County..... Caroline  
City or town..... Preston, Md. (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 30 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Caroline  
City or town..... Preston (If outside city or town limits, write RURAL and give nearest town)  
Street No..... (If rural, give LOCATION)  
2.(a) if veteran, name war.....

3. (a) FULL NAME  
Addie J. Wright

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife..... H. B. Wright

7. Birth date of deceased (mo. day, yr.) ..... Sept. 23, 1890

8. AGE: Years	Months	Days	If less than one day
55	6	4	hrs. min.

9. Birthplace..... Goldsboro, Caroline, Maryland  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

MOTHER FATHER 12. Name..... Robert Jarrell

13. Birthplace..... Caroline

14. Maiden name..... Addie Noble

15. Birthplace..... Caroline

16. Informant..... H. B. Wright

Address..... Preston, Md.

17. Burial Date thereof..... Mar. 31, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... M. E. Church Grave Yard

Location..... Preston Md.

18. Funeral director..... H. M. Hollis

Address..... Preston, Md.

19. March 30 1946 C. D. Blumer  
(Date rec'd by registrar) (Signature) (Title)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 27 1946 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 11 1946 to May 27 1946  
and that I last saw her alive on May 27 1946

Immediate cause of death..... Cerebral Hemorrhage  
DURATION 10 hr

Due to..... Hypertension  
Due to.....

Other conditions..... Previous Cerebral  
Hemorrhage 1941  
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. E. Lennon M.D.

M. D. or other

Address..... Federalsburg Md. Date signed May 29 1946

APR 1 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

02491

## CERTIFICATE OF DEATH

Reg. Dist. No. 63

## 1. PLACE OF DEATH:

County.....

City or town.....

Caroline

Dear, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Years. Months. Days.

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife.....

Thos. Peabody, Jr.

7. Birth date of deceased (mo., day, yr.)

Dec. 19<sup>th</sup> 1863

(6. c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

82.

2

15

hrs. min.

9. Birthplace.....

Penns.

(Town, county, and state)

10. Usual occupation.....

at home

11. Industry or business

MOTHER FATHER

12. Name.....

Josie

Martino

Josie Martino

Penns.

Penns.

13. Birthplace.....

Penns.

Penns.

14. Maiden name.....

Josie

Sesale

Penns.

15. Birthplace.....

Penns.

Penns.

16. Informant.....

Josie

Sesale

Penns.

Address

100

Preston

St.

Baltimore

Md.

2120

1946

Date of op.

Burial

(Burial, cremation, or removal. Which?)

Bedford Cemetery

Cemetery or crematory

Evans

La.

Location

J. Siegel &amp; Son

Funeral director

Address

100

Preston

St.

Baltimore

Md.

2120

1946

Date signed

March 2

1946

Date rec'd by registrar

Condor Plummer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Caroline

City or town.....

Hermans

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 2 1946 at 11:00 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15<sup>th</sup> to March 19<sup>th</sup>, 1946, and that I last saw her alive on February 28, 1946.

Immediate cause of death.....

Chronic Myocarditis, 1 yr +

Due to..... General arteriosclerosis, 1 yr +

Due to..... age

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

William C. Harrison MD

M. D. or other

Herrick Md.

Address.....

Date signed.....

